Massachusetts State Defense Force
Application Instructions

Those persons interested in serving with the MSDF should first consult TAGMA Pam 10-6-1 (MSDF Personnel Management) in order to determine their eligibility for membership. Prospective applicants should review Paragraph 2-3 as well as the appropriate section for either officers (Paragraphs 3-1 and 3-2), warrant officers (Paragraph 4-1), or enlisted personnel (Paragraph 5-1).

All applicants will submit the following to the MSDF for processing (see Paragraph 6-1, TAGMA Pam 10-6-1):

1. MSDF Membership Application (be sure to initial each page)

2. DD Form 2807-1 (Report of Medical History)

3. Copy of birth certificate, documentation of lawful permanent residency, or evidence of citizenship

4. Verification of Social Security Number (copy of Social Security card will suffice for this requirement)

5. Copies of all DD Forms 214 and/or NGB Forms 22

6. Copies of any military awards not annotated on a DD Form 214 or NGB Form 22

7. MSDF CORI Form

8. Evidence of highest civilian schooling attained

9. Evidence of highest military schooling attained

10. Evidence of valid motor vehicle operator permit and certified driving record

11. (For professional appointments only) Proof of current, unrestricted licensure, registration, certification, or ecclesiastical endorsement

<u>Be sure to maintain a photocopy of all information submitted for your own records.</u>

All applications should be mailed to:

Massachusetts State Defense Force
Joint Force Headquarters
50 Maple Street
Milford, MA 01757

Massachusetts State Defense Force
Membership Application

1. General Information

Answer each question in the space provided.

Last Name	First Name	Middle Name	
Date of Birth	Place of Birth	SSN	Sex
Home Address (Street)	City	State	Zip
Mailing Address (if different)	City	State	Zip
Home Telephone	Alternate (Cell) Telephone	E-Mail Address	
Marital Status	Next of Kin	Relationship	
Next of Kin Home Address	City	State	Zip

2. Civilian Education

List all schools attended (attach additional sheet if necessary).

High School	City	State	Year
College	City	State	Year
Graduate School	City	State	Year
Chief Undergraduate Subject		Undergraduate Degree	
Chief Graduate Subject		Graduate Degree	

3. Work History

Cover the last 5 years (attach additional sheet if necessary).

May inquiry be made of your present employer regarding your character, qualification, and record of employment? (A "No" answer will not affect your consideration for memebrship.)	Yes ☐	No ☐

Name and Address of Employer	Dates Employed From	To
Title of Position	Supervisor Name and Telephone Number	Number of Employees Supervised
Type of Business	Reason for Leaving (Leave Blank if Currently Employed)	
Description of Work		

Name and Address of Employer	Dates Employed From	To
Title of Position	Supervisor Name and Telephone Number	Number of Employees Supervised
Type of Business	Reason for Leaving	
Description of Work		

4. Skills and Qualifications

List any current professional licenses/certification (attach copies to this application)

List any special skills/qualifications with software, emergency management, logistics, communications, public health, etc. (attach additional sheet if necessary).

Applicant's Initials _____

5. Military Experience

Attach additional sheet(s) if necessary.

Military Service: Start with most recent service and show changes in grade and duty in reverse chronological order.

From	To	Component	Grade	Organization	Duty

Military Education: Enter information for all military courses successfully completed.

Resident Courses	Duration		Correspondence Courses	Hours
	Weeks	Days		

Military Qualifications: List any Military Occupatinal Specialty and Secondary Skill Identifier awarded on orders.

MOS/SSI	Date Awarded	How Qualification was Obtained (Service School, On the Job Training, Civilian Experience, etc.)

6. Personal Background Questionnaire

YES	NO	All applicants must complete; attach separate sheet(s) fully detailing any "YES" answers (except questions 9 and 10).
☐	☐	1. Have you ever been convicted of a felony by any civilian or military court?
☐	☐	2. Are you currently on parole or probation?
☐	☐	3. Have you ever been dropped from the rolls or released from any Uniformed Service of the United States under other than honorable conditions, for unsatisfactory service, by resignation in lieu of court martial, by elimination for any form of corrective or disciplinary action, for the good of the service, or for presenting a security risk?
☐	☐	4. Have you ever received a military discharge with a reenlistment code of either RE-4 or RE-3?
☐	☐	5. Are you presently serving in the Armed Forces of the United States or any reserve component thereof?
☐	☐	6. Are you presently serving in the State Defense Force of any other state or territory?
☐	☐	7. Have you ever been discharged for cause by the State Defense Force of this or any other state or territory, the Civil Air Patrol, the U.S. Coast Guard Auxiliary, or any similar organization?
☐	☐	8. Are you a member of any paramilitary training organization not authorized by Congress or the Massachusetts General Court?
☐	☐	9. Do you meet MSDF heigh/weight standards outlined in Appendix B of TAGMA Pam 10-6-1?
☐	☐	10. (*Males born after December 31, 1959 only*) Are you registered with the Selective Service System?

Applicant's Initials _____

7. Information Use and Safeguarding

The primary use of information provided on this application is to determine your eligibility for membership in the Massachusetts State Defense Force. As such, this information may be disclosed to individuals and agencies as required to investigate your statements. Furnishing the information on this form, including your Social Security Number, is voluntary, but failure to do so may result in disapproval of this application. The safeguarding of information you provide is governed by the provisions of Massachusetts General Laws (MGL) Chapter 4, Section 7, Clauses 26 (a) - (s); MGL Chapter 66; and MGL Chapter 66a.

8. Statements of Understanding, Certification, and Authorization for Release of Information

I understand that members of the Massachusetts State Defense Force serve in a voluntary and generally uncompensated capacity and will only be paid in the event that they are called into active state military service. I further understand that members of the Massachusetts State Defense Force shall be required to attend reasonably scheduled drill periods (at least one per quarter) in order to satisfy performance standards.

My statements on this form, and on any attachments to it as well as all other forms required to complete the Massachusetts State Defense Force application process, are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I have carefully read the foregoing instructions to complete this and all other applicable forms. I understand that a knowing and willful false statement on this and other required forms can be punished as allowed by law. I understand that intentionally withholding, misrepresenting, or falsifying information may have a negative effect on my ability to serve in the Massachusetts State Defense Force and/or may result in my removal and debarment from state military service.

I have completed this application and all related/required forms with the knowledge and understanding that any or all items contained herein may be subject to investigation as permitted by law. I consent to the release of information concerning my capacity and fitness by any employer (except my present employer if so indicated in Section 3 of this application form), educational institution, law enforcement agency, and/or other individuals and agencies to MSDF S1 personnel for the purposes of verifying my information and determining my suitability for membership in the Massachusetts State Defense Force. This authorization is valid for the entirety of my affiliation with the Massachusetts State Defense Force.

Print Full Name:	
Signature:	Date:

Applicant's Initials _____

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413
OMB approval expires Mar 31, 2010

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397 (SSAN).
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confine- ment or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*	5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
b. HOME TELEPHONE *(Include Area Code)*	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION		7.a. POSITION *(Title, Grade, Component)*
[ ] Army [ ] Coast Guard	[ ] Active Duty	[ ] Enlistment	[ ] Medical Board [X] Other *(Specify)*	
[ ] Navy	[ ] Reserve	[ ] Commission	[ ] Retirement MSDF	b. USUAL OCCUPATION
[ ] Marine Corps	[ ] National Guard	[ ] Retention	[ ] U.S. Service Academy	
[ ] Air Force		[ ] Separation	[ ] ROTC Scholarship Program	

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*	9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. **FEMALES ONLY.** Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. **EXPLANATION OF "YES" ANSWER(S)** *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

Additional information required by the Massachusetts State Defense Force to be completed by the Provider:

1. Blood Pressure: _____ Heart Rate: _____ Height: _____ Weight: _____

2. Brief description on examination of the following (use additional space below if necessary):

   2a. Cardiovascular System: _____

   2b. Lungs: _____

   2c. Abdomen: _____

   2d. Extremities: _____

3. Listing of all medications: _____

   _____

4. Pertinent laboratory data (e.g. HgA1c): _____

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

The Commonwealth of Massachusetts
Military Division

50 Maple Street
Milford, Massachusetts 01757
Tel: (508) 233-6552
www.mass.gov/guard

CORI REQUEST FORM

The Massachusetts National Guard is certified by the Criminal History Systems Board for access to the conviction and pending criminal case data in order to screen members and employees of the Commonwealth's Armed Forces and Military Division; I understand that a criminal record check will be conducted on me. The information below is correct to the best of my knowledge.

_____ _____
Participant/Volunteer Signature Date

PARTICIPANT/VOLUNTEER INFORMATION (PLEASE PRINT)

_____ _____ _____
Last Name First Name Middle Name

_____ _____ _____
Date of Birth Place of Birth Mother's Maiden Name

_____ _____ _____
Maiden Name or Alias (If Applicable) | Social Security Number (Optional – Not Required) | ID Theft Index PIN (If Applicable)

Former Addresses:_____

_____

Sex: _____ Height: _____ ft _____in Weight: _____ Eye Color: _____

Driver License Number: _____ State of Issue: _____

MILITARY DIVISION USE ONLY

THE ABOVE INFORMATION WAS VERIFIED BY REVIEWING THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: _____

Requested by: _____
Signature of CORI Authorized Employee

CHSB USE ONLY

Record Attached:_____ No Record:_____